PATIENT DATA

Please print, fill out in blue pen & bring with you for your appointment

First Name:
Middle Initial:
Last Name:
Nickname:

Social Security#:
Date of Birth:
Age:
Gender: ○ Male ○ Female

Organization:
Mail Code:
Work Phone:
Home Phone:
E-mail: ○ Yes ○ No

Building/Room:
Shift: ○ 1 ○ 2 ○ 3 ○ TDY
Job Description:
Supervisor's Name:
Supervisor's Phone:

Have you ever been to RehabWorks before?: ○ Yes ○ No

If YES, please give approximate date/year: _____

Place injured: ○ Home ○ Work ○ Sport ○ Other

Is this a Workers' Comp Injury: ○ Yes ○ No

If so, please complete the following:

Workers' Comp Name:
Workers' Comp Phone:
Workers' Comp Fax:

ONLY SIGN BELOW IF THIS IS A WORKERS' COMP INJURY:

Statement of Consent for Release of Information

I authorize RehabWorks to release the medical information contained in my patient records pertaining to the workers' compensation injury for which I am currently being treated by RehabWorks to my physician and/or workers' compensation representative for the purpose of progress notes and/or case management.

Employee Signature _____ **Date** _____

Medical History Form

Name: _____

Do you currently have or have had problems with:

	Please select one		Please provide details:
Angina/chest pain	☐ Yes	☐ No	
Arthritis Area:	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Back injury	☐ Yes	☐ No	
Balance problems	☐ Yes	☐ No	
Blackout/fainting	☐ Yes	☐ No	
Bleeding problems	☐ Yes	☐ No	
Blood clots or phlebitis Area:	☐ Yes	☐ No	
Bone fractures Area: 1 _____ 2 _____ 3 _____ 4 _____ 5	☐ Yes	☐ No	
Cancer Area:	☐ Yes	☐ No	
Cardiac catheterization	☐ Yes	☐ No	
Cough	☐ Yes	☐ No	
Diabetes Type:	☐ Yes	☐ No	
Dislocation/subluxation Area: 1 _____ 2 _____ 3	☐ Yes	☐ No	
Epilepsy/seizures	☐ Yes	☐ No	
Gout Area:	☐ Yes	☐ No	
Heart attack	☐ Yes	☐ No	
Heart failure	☐ Yes	☐ No	
Heart murmur	☐ Yes	☐ No	
Heart valve problems	☐ Yes	☐ No	
Heartburn	☐ Yes	☐ No	
Hepatitis/jaundice	☐ Yes	☐ No	
Hernias Area:	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No	
Infectious disease	☐ Yes	☐ No	
Migraines/headaches	☐ Yes	☐ No	
Motor vehicle accident	☐ Yes	☐ No	
Neck injury Area:	☐ Yes	☐ No	
Numbness/tingling Area:	☐ Yes	☐ No	
Osteoporosis	☐ Yes	☐ No	

Palpitations	☐ Yes	☐ No	
Prednisone usage	☐ Yes	☐ No	
Prior cardiac surgery	☐ Yes	☐ No	
Prostate/kidney problem	☐ Yes	☐ No	
Scoliosis	☐ Yes	☐ No	
Shortness of breath	☐ Yes	☐ No	
Sprain Area: 1 _____ 2 _____ 3 _____ 4	☐ Yes	☐ No	
Stomach ulcers	☐ Yes	☐ No	
Strain Area: 1 _____ 2 _____ 3 _____ 4	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Other	☐ Yes	☐ No	

Injury History

Date of injury: _____

How did your injury occur (describe briefly):

_____

_____

Medications ☐ N/A

Please list any prescription or over-the-counter medicines that you are currently taking:

_____

_____

Allergies ☐ NKA (No Known Allergies)

Please list any known allergies to medications:

_____

Past surgical history ☐ N/A

Surgery:	Year:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Smoking History

Currently smoking? ☐ Yes ☐ No _____ packs/day for _____(s)

Quit smoking? ☐ This year ☐ >1 year ☐ >5 years ☐ >10 years

Previously smoked _____ packs/day for _____ (s)

Exercise History Please select one:

○ Daily ○ Weekly ○ Monthly ○ Rarely ○ Never

Medical Hx Reviewed by _____ **MS, ATC, LAT** **Date** _____

Outcome Assessment

Patient Name: _____

Please fill out left hand side only for 1st appointment

PATIENT: Your responses to this questionnaire will help your athletic trainer and this clinic determine rehabilitation outcomes for specific medical conditions in response to specific treatments. This will help us optimize our treatment services to you and other patients. Your responses will be kept confidental and will not affect your care in any way. Thank you for your assistance.

INSTRUCTIONS:

Please rate your current capacities specific to the injury for which you will receive, or have received treatments. Please answer all questions as best you can, even if some of the questions seem somewhat irrelevant to you. Circle the appropriate response according to the (0 1 2 3 4) scale; 0=critical problem, 1=severe problem, 2=moderate problem, 3=minor problem, 4=no problem.

Date: _____ fill out for 1st appt.							**Date:** _____ fill out at time of discharge				
Critical Problem	Severe Problem	Moderate Problem	Minor Problem	No Problem			Critical Problem	Severe Problem	Moderate Problem	Minor Problem	No Problem
0	1	2	3	4	**General health -** feel good, happy, energetic, active, relaxed, free of medication, free of pain/discomfort, appetite, body composition (body weight; obesity, anorexia)...		0	1	2	3	4
0	1	2	3	4	**Specific medical condition -** status of injury, illness, surgery...		0	1	2	3	4
0	1	2	3	4	**Daily living activities -** sleeping, sitting, standing, walking, climbing stairs, dressing, personal care, studying (reading, writing, typing/computer), traveling, driving, personal business affairs...		0	1	2	3	4
0	1	2	3	4	**Work activities -** lifting/lowering, holding/handing, carrying, pushing/pulling, bending over, squatting/stooping, kneeling, crawling, reaching, turning/pivoting, gripping/pinching, fingering...		0	1	2	3	4
0	1	2	3	4	**Sports/recreation/wellness activities -** running, jumping, throwing, catching, kicking, swinging, withstanding impacts, weightlifting, specific sport/recreation/wellness activity...		0	1	2	3	4
0	1	2	3	4	**Movement -** getting into desired positions, range of motion, speed of motion, bilateral differences, (e.g. limping), need for support device...		0	1	2	3	4
0	1	2	3	4	**Strength/power -** applying adequate force, applying force at necessary speeds or frequencies..		0	1	2	3	4
0	1	2	3	4	**Endurance -** sustaining a movement pattern over a long period of time, sustaining a faster paced or more strenuous movement pattern over a short period of time...		0	1	2	3	4
0	1	2	3	4	**Motor abilities -** motor control, coordination, balance, agility, reflexes...		0	1	2	3	4
0	1	2	3	4	**Body structure -** swelling, inflammation, atrophy, deformity, posture, bilateral differences, joint stability, muscle spasms..		0	1	2	3	4
0	1	2	3	4	**Sensory -** pain, sensitivity, discomfort, numbness...		0	1	2	3	4
0	1	2	3	4	**Psycho-social status -** confidence, anxiety, self-esteem, hopeful, depression, socialization, dependence, isolation...		0	1	2	3	4

***At discharge,** please rate your satisfaction with the treatment services provided, and your athletic trainer. Optional: circle any aspects that you were not satisfied with. List other concerns.*

					Satisfaction with treatment services: Treatment Schedule - scheduling, following schedule, accessibility: Facility - location, parking, appearance, equipment: Treatment Environment - physical, social...		0	1	2	3	4
					Satisfaction with your athletic trainer: Communications, professionalism; Rehab-appropriate to my needs, effective		0	1	2	3	4
							very unsatisfied	unsatisfied	moderately satisfied	satisfied	very satisfied

At time of discharge, please return to: KSC RehabWorks, Mail Code: BIO-8